

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 002408	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/07/2013
NAME OF PROVIDER OR SUPPLIER DUPONT HOSPITAL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2520 E DUPONT RD FORT WAYNE, IN 46825		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 30405 Facility Number: 002408</p> <p>Type of Survey: State Licensure Off Site JCAHO Accreditation Survey</p> <p>Date of JCAHO On Site Survey - Hospital full survey March 5 -7, 2013</p> <p>Date of ISDH off site review - July 26, 2013</p> <p>Reviewer/Surveyor - Deborah Franco RN, PHNS</p> <p>Based on review of the March 5 -7, 2013 JCAHO Accreditation Survey Report, it has been determined that Dupont Hospital meets the requirements for Hospital Licensure in Indiana.</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1